Little Hoover Commission
Public Hearing on Public Health
Thursday, June 27, 2002

Testimony of Carmen Rita Nevarez, MD, MPH

I am the Medical Director and Vice President for External Relations of the Public Health Institute and the former Health Officer and Director of the Department of Health and Human Services for the City of Berkeley. I have been asked to testify about issues in the public health system that need strengthening in order to protect the public's health in the situation of a bioterrorist incident.

As the fourth largest economy in the world, a terrorist attack that could cripple California would be a grand prize to a hostile power. An ideal/model public health system would respond adequately to a terrorist threat against the public health of Californians, and would have a strong statewide leadership, with responsive coordinated data and communications systems between government, health providers, voluntary agency partners, and the public. The model public health system should be supported by a reliable infrastructure with a capacity adequate to meet the needs of the California's 35 million residents and be fully coordinated with other elements of the disaster response system. This fully coordinated system would need to protect residents against either infectious agents that could have very rapid dissemination as well as attacks involving the food or water supply, or deliberate contamination of the air. [a] It is likely that in such an event, all of the elements of the system would be required to work in a tightly synchronous fashion, but in only one or two major population centers at any one time.[b]

As your Commission has rightly recognized, the capacity of California's public health systems have become greatly hobbled, and the public's health is unprotected whether the enemy be intentional criminal biologic attack or simply a severe outbreak event. The same system that protects Californians from infectious disease is the one that would protect us from a terrorist threat of biologic nature, whether it is from an infectious bioweapon, food or water contamination, or pollution of the air.

This testimony will attempt to break down these challenges according to some of the crucial elements of California's Public Health System; Leadership, Data, Communications, Infrastructure, and Partnerships and offer reasonable and timely recommendations.

Leadership

At the highest level of state government, public health leadership is vulnerable to political influence. In contrast to local health departments, where the health officer's authority extends for the length of their employment spanning from 5 to 20 years, the state health officer is an appointee changing with each administration, oftentimes more frequently if the state heath officer has a disagreement with the governor. One dilemma of state leadership stems from the fact that it is embedded within a political environment. The

lack of insulation from political pressure and interference can lead health officials to an inability to play a full professional leadership role. In an anti-regulatory administration the state health officer will have difficulty regulating pesticide use. In a situation of a crushing budget deficit, public health leaders cannot appear to make demands on public funds by detailing the deficits of the system. Although this serves political purposes well, as the statewide professional leadership position protecting the public's health, this system could undermine the very basis of trust. In contrast, during the 1940's through 60's, a Board of Health provided professional leadership and guidance with a state health appointed leader whose term overlapped political administrations.

The state civil service system further works against attracting all of the professional public health talent that is needed at the state level because the salary structure compares very unfavorably to other health sectors. Talented individuals dedicated to public service have many considerations, not the least of which is the wide scope and high pressure of a position with a salary fixed at a level below that of the directors of most local health departments.

In addition, as currently configured, the vast majority of the Department's resources are dedicated to medical care financing and regulatory issues. There has been little focus on the public health infrastructure at the top levels of state government in the last few decades.

RECOMMENDATION: There be created a public health board (authority) of 3-5 public health expert members with overlapping terms of office to provide professional public health advice to the governor with the charge of restoring the public health infrastructure to a capacity level consistent with maintaining the state's health status and maintaining those systems and structures necessary to protect the public health from a bioterrorist incident.

Data

California's single purpose data systems (California Cancer Registry, Birth Defects Monitoring Program, OSHPD Hospital Discharge Data Base, etc.,) provide national models, for both protecting the privacy of individuals as well as providing much needed information to protect the public health. A single coordinated system that can identify changes in disease occurrence as well as geographic patterns of disease, a system that both actively and passively conducts surveillance for unusual conditions, a system for rapid identification of epidemic hazards including bioterrorism, is technically feasible but does not currently exist.

Barriers to such a system include gaps in data collection fueled by manpower deficits, financing, and institutional autonomy. Underutilization of existing systems, and a lack of sub-county information as a function of state policy further fuels the gap of being unable to track both community-level and supra-jurisdictional patterns of disease emergence that occur along commuter corridors. Sub-county data needed for effective interventions in communities does not exist.

Inadequate capacity to use data, lack of epidemiological expertise, and irregular and ineffective communication about community health status has led to negative perceptions in both community and professional sectors of local public health department competence. A poor record of effective communication about data to policymakers and communities results in lack of trust of government in general and public health agencies in particular.

RECOMMENDATION:
A state clearinghouse be established that would receive in real-time, all laboratory reports for a diagnosis set defined by DHS. The clearinghouse would provide a statewide and regional epidemiological capacity for analysis of disease clusters, which might signal bioterrorist events or emerging epidemics. The Clearinghouse would be designed to notify appropriate jurisdictional authorities in real-time.

Communications
In California, a state rich with media industry and expertise, no single secure, dedicated communications system that would facilitate and support the crucial need for the transfer of information during a bioterrorist incident exists. Even where the local health authority has a good relationship with the medical provider community, conditions of potential community threat are not reported in a timely manner. The East Coast anthrax experience pointed out the need for rapid dissemination of up to the minute scientific information to medical authorities and the public alike. This series of infectous agent exposures highlights the need for a standardized, statewide, communications system for swift transfer of data, information, and technical advice, with capacity for both in-coming and out-going communications. This system needs to be rapid, reliable, and connect various levels of government as well as health providers. The system will be required to share insights about the nature of the threat as it evolves, public health measures to contain the threat, and advice to medical providers. [c]

There also needs to be a standard system and protocol for communication with the public in a way that gives comprehensive and current information to the public and also informs them of risk as well as options as they evolve. Communication that is clear and media intelligent cannot be emphasized sufficiently. In these days of increasing internet access and media coverage, maintaining a consistent message which is scientifically reliable will be essential to forging and maintaining a trusting relationship with the public who play an essential role in responding to disasters.

RECOMMENDATION
The work begun with federal support to develop public health communications systems become a priority at the highest level of state government with the commitment necessary to develop a system capable of supporting a multisector approach to bioterrorism preparedness and response.

Infrastructure
Financing

An ongoing budget allocation of $1.0 million annually provides support to those communicable disease, surveillance, and control activities unfunded by categorical streams or block grants. This allocation, ranging from $5,000 to small contract counties, to amounts between $32,000 and $238,000 for Los Angeles and the 10 largest counties and leaves local health departments to find additional resources to fund disease surveillance activities. Efforts to augment this amount through "public health subvention" increases on an ongoing basis have failed repeatedly. California's 35 million residents are protected by this surveillance and control system, *the same system that would be activated in a bioterrorist incident*, supported at the funding level of $0.03 per person per year.

Manpower

California's manpower for the public health system is less than 30% degree trained. Continuing education offerings are slim; government personnel systems tend to be inflexible leading to loss of worker morale. Public health workers often need flexibility of hours and job function. In a disaster, whether natural or bioterrorist, the workforce is largely untrained in conventional disaster response and unintegrated into the unified command structure.

Cultural competence

According to the 2000 census, no racial or ethnic group forms a majority in California: white (47%), Latino (29%), Asian (11%), African American (6%), and multi-racial (5%). With this broad spread of diversity, the system that supplies response and recovery to communities must have the capacity to understand the patterns of behavior and communicate effectively with its residents. This capacity must be reflected in both the planning and program delivery stages in order to function during a time of great stress.

Accountability

Funding public health activities has always been a challenge. Local health officials dislike categorical funding streams because of their inflexibility to meet changing needs and because they are structured to respond to only those disease conditions that are politically popular. Block granted funds and grants lack accountability. In public health, the hallmark of effectiveness is control of communicable diseases and chronic disease rates; however, one cannot count events that do not happen. Control of infectious occurrences is only temporary in any case, as new conditions spontaneously develop. A flu pandemic similar to that of 1918 that killed 600,000 Americans over two flu seasons could easily overwhelm California's current response and recovery capacity.

Achieving accountability without categorical restrictions can be accomplished through accreditation of health departments, a process developing through a partnership between the Centers for Disease Control and Prevention and the National Association of County and City Health Officials (NACCHO).

RECOMMENDATION: Local health departments meet standards similar to those already developed through the NACCHO/CDC process modified to meet California's needs and linked to appropriate funding made available through the subvention process.[de]

Partnerships

"There are three lessons from recent events (September 11): first, public health systems have responded promptly to the suspicion of deliberate infections; second, these systems must continue to be vigilant; and third, an informed and responsible public is a critical part of the response." [1]

A successful public health response to bioterrorism is not accomplished by government working alone. When all is said and done, the local public health system's ability to respond to a disaster, whether it is natural or terrorist, consists of strong government leadership, professional and communications capacity and expertise, but is accomplished through essential partnerships with voluntary agencies, nonprofit agencies, for-profit providers, hospital networks, private physicians, churches, schools, and neighborhood associations. True cross-sectoral partnerships at all levels bring resources to bear in an effective and cost efficient way to respond to bioterrorist incidents.

RECOMMENDATION:

Model programs that enhance relationships between neighborhoods and health departments and that integrate community voice into planning should be encouraged as an integral element of the public health emergency response planning exercises. [f]

In conclusion, in this situation, incremental changes imposed on a neglected system are doomed to failure to the peril of the health of Californians. We will need to make bold commitments to the public health infrastructure in order to fully prepare California for the inevitability of a future catastrophic event whether natural or initiated by the hand of man.

---

[a] Roos, Robert, "Food supply's vulnerability to attack deserves more discussion, Osterholm says", Center for Infectious Disease Research and Policy, University of Minnesota, AND
Zilinskas, Raymond A., Ph.D. and Pate, Jason, MPM, EMT-1, "Responding to Bioterrorism: Assessing California's Preparedness" Monterey Institute of International Studies, prepared for the California Research Bureau.

[b] "Facing Reality in Preparing for Biological Warfare: A Conversation With George Poste", Health Affairs, Web Exclusive, June 5, 2002.

[c] Inglesby, Thomas V., MD, Congressional Testimony, U.S. Senate Committee on Government Affairs, "The State Public Health Preparedness for Terrorism Involving Weapons of Mass Destruction: A Six Month Report Card", April 18, 2002.

[d] National Association of County and City Health Officials, "Bioterrorism and Emergency Response Plan", "Bioterrorism Performance Standards".

---

[1] Director-General of the World Health Organization, Dr. Gro Harlem Brundtland

[ee] American Public Health Association – APHA, "The Essential Services of Public Health"
[f] Partnership for the Public's Health Annual Report 2001.

Public Health Funding – Addendum to Carmen Rita Nevarez' testimony

Funding for public health activities at the state and local level are primarily committed to categorical programs such as family planning, HIV-AIDS, Maternal Child Health, and other programs that strictly limit their use. Locally, there is a range of support depending on county policy, from "No net county costs" approach, to limited general subsidy, to some counties in which certain program functions may be augmented. To date, no county has appropriated local funds exclusively for bioterrorism response.

Support for bioterrorism response activities in provided by two streams, the State Public Health Subvention and new funds being made available through federal resources. The ongoing annual allocation for Public Health Subvention is $1.0 million statewide. This year's budget was supplemented by a one-time Governor's appropriation of $5.0 million.

New federal funds from CDC being made available to address bioterrorism at the local health department level include $7.5 million in this year and $28.5 million in next year. These funds will be directed primarily to local planning, epidemiology, laboratory, communications, and training activities according to the State's Bioterrorism Response Plan. These funds apply to all of California excluding Los Angeles County that includes the local health jurisdictions of Pasadena and Long Beach (they receive separately a total of $$26 million). In FY 2003-2004 current discussion by the Administration and in Congress suggests that as much as $4 billion may be appropriated nationally for state and local preparedness.

In addition, federal sources (HRSA) are making $14 million available to assist hospital system preparedness. These funds will be distributed through Emergency Medical Services Authority (EMSA).